Tooth Berry Kids DENTAL

Medical History

Your Child's Name:____Date:________________ M/F
Date of Birth:_______/_______/_______ Medical Alert:____
Home Phone:___________________________

Is your child under the care of a physician?................................☐Yes ☐ No If Yes, please describe:____________________________
Is your child taking any medications? (Prescription, over the counter)... ☐Yes ☐ No Yes, Please describe:______________________
Have you ever been told that your child needs antibiotics or premeds before treatment? ☐Yes ☐ No
If yes, please describe:____
Does your child have any allergic (or adverse) reaction to any medication or other substance? ☐Yes ☐ No
If yes, please describe:____
Are your child's immunizations current ?.. ☐Yes ☐ No

Women only

Yes No Are you pregnant or think you might be?

Yes No Breastfeeding?

List any Hospitalizations, Surgeries, Serious Illnesses ¿When?

____ _________________________
____ _________________________
____ _________________________

Indicate which of the conditions your child has now or ever has had. Mark each answer individually.

AIDS/HIV positive	☐Yes ☐ No	Behavioral/ Learning Problem	☐Yes ☐ No	Kidney/Liver problem	☐Yes ☐ No
Allergies or Hives	☐Yes ☐ No	Bleeding Disorder	☐Yes ☐ No	Latex sensitivity	☐Yes ☐ No
Anemia	☐Yes ☐ No	Hepatitis A B C	☐Yes ☐ No	Hearing problem	☐Yes ☐ No
Epilepsy	☐Yes ☐ No	Diabetes	☐Yes ☐ No	Lung Problem	☐Yes ☐ No
Mononucleosis	☐Yes ☐ No	Hay Fever	☐Yes ☐ No	Measles/Mumps	☐Yes ☐ No
Asthma	☐Yes ☐ No	Cancer	☐Yes ☐ No	Autism	☐Yes ☐ No
Handicaps/Disabilities	☐Yes ☐ No	Chicken Pox	☐Yes ☐ No	Psychiatric/psychological	☐Yes ☐ No
Nervous disorders	☐Yes ☐ No	Heart condition	☐Yes ☐ No	Brain injury	☐Yes ☐ No
Cerebral Palsy	☐Yes ☐ No	Sickle cell anemia	☐Yes ☐ No	Stomach Problem	☐Yes ☐ No
Tuberculosis	☐Yes ☐ No	Rheumatic/Scarlet fever	☐Yes ☐ No		

Other?.........................Yes No, If Yes please specify:
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I understand that the above information is necessary to provide my child with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask my respective health care provider or agency, which may release such information to you. I will notify the doctor of any change in my child's health or medications.

Patient Name (PRINT) ____Date________________
Parent/Guardian Signature____Date________________
Doctor's Signature____Date________________
Witness Signature ____Date________________